TENNESSEE GENERAL ASSEMBLY
FISCAL REVIEW COMMITTEE

# FISCAL NOTE

## HB 2390 - SB 2213

February 28, 2016

**SUMMARY OF BILL:** Requires a health insurance entity, no later than 10 calendar days after receiving a claim by electronic submission for medical care for which the cost was preapproved, in whole or in part, under a health insurance entity's preauthorization process to: (1) pay the total covered cost of the claim if the entire cost of the claim was preapproved or (2) pay the preapproved portion of the cost of the claim and notify the provider why any remaining portion of the cost of the claim will not be paid and what substantiating documentation or information, if any, is required to adjudicate the claim.

Defines preauthorization as the process by which the utilization review agent determines the medical necessity of otherwise covered health care services prior to the rendering of such health care services including, but not limited to, preadmission review, pretreatment review, utilization, and case management.

## ESTIMATED FISCAL IMPACT:

**Increase State Expenditures -- $1,119,900**

**Increase Federal Expenditures -- $694,391**

Assumptions:

- Pursuant to Tenn. Code Ann. § 56-7-109, a health insurance entity or third-party administrators (TPAs) have 21 calendar days to pay a claim for which prior authorization was provided and subsequently, a service was provided to the insured; however, prior authorization does not necessarily mean the claim will be paid in full despite receiving such authorization.
- A claim may be approved by prior authorization and the provision of care performed; the insurer may afterwards determine that only a portion of the claim is clean. A clean claim requires no further information from the healthcare provider and therefore, will be reimbursed. If a portion of the claim is judged unclean by the insurer, such insurer must notify the provider in writing of all the reasons the claim is not clean and will not receive reimbursement. The insurer must subsequently provide the healthcare provider what information must be received to adjudicate the unclean portion as clean.
- Requiring a claim to be paid within 10 days of electronic submission will limit health insurers' ability to perform pre-pay reviews and therefore, catch portions of claims that received prior authorization, but upon further review, would have been adjudicated as

lacking documentation and information supporting the claim. It is assumed that insurers will need additional personnel to perform expedited reviews on such claims.

- The Department of Finance and Administration, Division of Benefits Administration has two TPAs. In calendar year 2014, the carriers adjudicated 8,683,853 claims. Approximately five percent of the claims or 434,193 (8,683,853 claims x 0.05) received prior authorization. Assuming the same volume of claims for FY16-17 and subsequent years, these carriers will need to dedicate personnel to effectively adjudicate these claims and meet the required 10-day limit.
- The Division compensates the TPAs by an actuarially determined per-member per-month fee. Based on information provided by the Division, the increase in state expenditures to adjudicate these claims is estimated to be $745,750.
- The Bureau of TennCare contracts with three TPAs. It is estimated each TPAs will incur increases in personnel and system costs to effectively review claims to meet the 10-day time limit. The total increase in expenditures to the Bureau's three TPAs for operational and personnel costs are estimated to be $1,068,573 ($232,382 for the first TPA + $480,000 for the second TPA + $356,191 for the third TPA).
- Medicaid expenditures receive a federal match rate estimated to be 64.983 percent. The state funding will be 35.017 percent.
- The increase in state expenditures is estimated to be $374,182 ($1,068,573 x 0.35017).
- The total recurring increase in federal expenditures is estimated to be $694,391 ($1,068,573 x 0.64983).
- The total recurring increase in state expenditure is estimated to be $1,119,932 ($745,750 + $374,182).
- Based on information provided by the Department of Commerce and Insurance, the proposed legislation will have a minimal impact on the Division and can be enforced using existing resources within the Department.

## IMPACT TO COMMERCE:

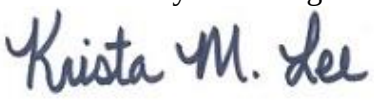
**Increase Business Revenue -- $1,814,300**
**Increase Business Expenses --$1,814,300**

Assumptions:

- TPA's and healthcare providers will experience an increase in business expenditures of at least $1,814,323 ($694,391 + $1,119,932).
- Insurers and healthcare providers will pass on such costs to plan subscribers by increasing rates. Due to multiple unknown factors, the extent to which insurance providers will increase premiums to offset rising costs is unknown.
- It is likely that requiring a 10-day turnaround on claim reimbursements will result in healthcare providers experiencing an increase in revenue due to insurers' inability to perform pre-pay review on claims with prior authorization. Due to multiple unknown factors, this impact cannot be quantified.

**CERTIFICATION:**

The information contained herein is true and correct to the best of my knowledge.



Krista M. Lee, Executive Director

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